

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12647

CERTIFICATE OF DEATH

12633

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Hanover</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fulton</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bowie</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sunray Rest Home</i>		d. STREET ADDRESS <i>16x-2</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Arthur</i>	Middle <i>Walter</i>	Last <i>Bell</i>	
4. DATE OF DEATH	Month <i>November</i>	Day <i>21</i>	Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 23, 1884</i>	
9. AGE (In years last birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cooperator</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Andrew Bell</i>	14. MOTHER'S MAIDEN NAME <i>Susan Waters</i>	Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Wm. Tratt</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i> DUE TO <i>(c)</i>	INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic heart disease</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Clarksville, Maryland</i>	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 6</i> , 1957, to <i>Nov. 22</i> , 1959, that I last saw the deceased alive on <i>Nov. 20</i> , 1959, and that death occurred at <i>7:30 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Charles S. Whitaker</i> , M.D. ADDRESS (Street, city or town, state) <i>Clarksville, Maryland</i> DATE SIGNED <i>11-23-59</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/24/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Trinity Meth. Church</i>	22d. LOCATION (City, town, or county) (State) <i>Patapsco, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Williams, Laurel, Md.</i>	ADDRESS <i>Laurel, Md.</i>	24a. REC'D BY REGISTRAR DATE NOV 25 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

WISCONSIN STATE GOVERNMENT OF THE HABITAT FOR HUMANITY

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12648 CERTIFICATE OF DEATH

12634

Reg. Dist. No

1. PLACE OF DEATH GUILFORD ROAD HOWARD CO.			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) MARYLAND		
a. COUNTY MARYLAND			a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JESSUP			b. COUNTY MONTGOMERY		
c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS 8925 BROOKVILLE ROAD		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1556-2		
3. NAME OF DECEASED (Type or print) ADA REBECCA CRAFT		First	Middle	Lost	4. DATE OF DEATH 11/19/1959
5. SEX Female		6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 28, 1890	9. AGE (In years lost, birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Charlton, Va.	
12. CITIZEN OF WHAT COUNTRY U.S. A.					
13. FATHER'S NAME Stephen Thomas Graves		14. MOTHER'S MAIDEN NAME EMMA Dora (GRAVES) Royal		Address Box 123, Jessup, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Silas E. Craft, Sr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. 420.1		(b) Myocardial infarction		2 hr.	
(c) Arteriosclerosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 320 Montgomery, Laurel, Md. (County) Laurel (State) Md.	
21. I certify that I attended the deceased from May 17, 1959 to Nov. 19, 1959 , that I last saw the deceased alive on Nov. 17, 1959 , and that death occurred at 8 P.M. from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) 320 Montgomery, Laurel, Md. DATE SIGNED 11/19/1959					
ACTUAL SIGNATURE Hank V. Weimer					
PHYSICIAN'S NAME (Type) Hank V. Weimer					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/24/59		22c. NAME OF CEMETERY OR CREMATORIAL Carver Memorial Park	
22d. LOCATION (City, town, or county) Laurel, Md.		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert D. Snowden					
ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR NOV 30 1959		24b. REGISTRAR'S SIGNATURE John S. Kline	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM P/SS

BY 2000 WITH THE ESTABLISHMENT OF THE INTERNATIONAL STAGE OF THE JAPANESE

1957-1963 AGTB

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS AISC 15-10M —

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12635

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Woodbine R.F.D.				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Howard CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Woodbine R.F.D.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) Florence			
3. NAME OF DECEASED (First) (Type or Print) Raymond				(Middle) Clark (Last) Duvall			
4. DATE (Month) OF DEATH Nov. 9 1959				(Day) (Year)			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Aug. 27 1893	
9. AGE last birthday 66 yrs.		10. KIND OF BUSINESS OR INDUSTRY County Roads		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Duvall				14. MOTHER'S MAIDEN NAME Florence Duvall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218 09 0963			
17. INFORMANT & ADDRESS Mary E. Duvall Same as 2				18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 191.3 IMMEDIATE CAUSE (A) Malignant degeneration sebaceous gland 3 yrs ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____			
19a. DATE OF OPERATION 6/3/58				19b. MAJOR FINDINGS OF OPERATION Squamous cell carcinoma of face			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21e. INJURY OCCURRED M. While at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR? 22. I hereby certify that I attended the deceased from 7/26....., 1958..... to 10/9....., 1959....., that I last saw the deceased alive on 11/9/....., 1959....., and that death occurred at 3:00 M, from the causes and on the date stated above. SIGNATURE <i>John Meadow M.D.</i> ADDRESS (Street, city, town, state) M.D. Main Street, Damascus, Md. DATE SIGNED 11/10/59			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov. 12 59		NAME OF CEMETERY OR CREMATORIAL Jennings Chapel		LOCATION (City, town, or county) Howard Co. Md. (State)	
24. REC'D BY REGISTRAR DATE NOV 13 '59		REGISTRAR'S SIGNATURE <i>John E. K.</i>		25. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber		ADDRESS Laytonsville, Md.	

RECEIVED
IN THE STATE LIBRARY
OF THE STATE OF CALIFORNIA

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
John Doe	55 yrs	Male	Heart Disease
ADDRESS	STREET	CITY	STATE
123 Main Street	123 Main Street	Los Angeles	California
NAME OF DOCTOR	STREET	CITY	STATE
Dr. John Smith	123 Main Street	Los Angeles	California
NAME OF FUNERAL DIRECTOR	STREET	CITY	STATE
John Doe	123 Main Street	Los Angeles	California
NAME OF CEMETERY	STREET	CITY	STATE
John Doe Cemetery	123 Main Street	Los Angeles	California
DATE OF DEATH	TIME OF DEATH	DATE OF CERTIFICATE	TIME OF CERTIFICATE
12/12/00	12:00 PM	12/12/00	12:00 PM

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12636

Reg. Dist. No.

12650

1. PLACE OF DEATH a. COUNTY <u>Howard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN 1b <u>13 yrs.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Ellicott City</u>		
d. STREET ADDRESS <u>1 R.F.D. 144 Frederick Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> - <u>FRANZ-Goehring</u>		First	Middle	
4. DATE OF DEATH <u>Nov. 13 1959</u>	Month	Day	Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14/1901</u>	
9. AGE (in years last birthday) <u>58 yrs.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Auto. Garage</u>	11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Ferdinand Goehring</u>	14. MOTHER'S MAIDEN NAME <u>Georine Muhler</u>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>217-20-7797</u>	17. INFORMANT <u>Mrs. Elsa M. Goehring</u>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>	Address <u>R.F.D. 2 Ellicott Md.</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>		
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>				
ACTUAL SIGNATURE <u>George E. Burgtorf</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>11-14-59</u>
EXAMINER'S NAME (Type) <u>GEORGE E. BURGTORF</u>	22b. DATE THEREOF <u>Nov. 16, 1959</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Good Shepherd Cem.</u>	22d. LOCATION (City, town, or county) <u>Howard County Md.</u>	(State)
22e. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Truman Schub</u>	ADDRESS <u>3512 Frederick Ave.</u>	24a. REC'D BY REGISTRAR <u>NOV 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>John S. Evans</u>

2000 file 3

• 2020 EDITION

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200 E. L. GALT

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Geometric sequences

Centrifuge

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Other to the author

www.EasyEngineering.net

Задачи. Графы. Деревья

TO HOSPITAL OR PENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

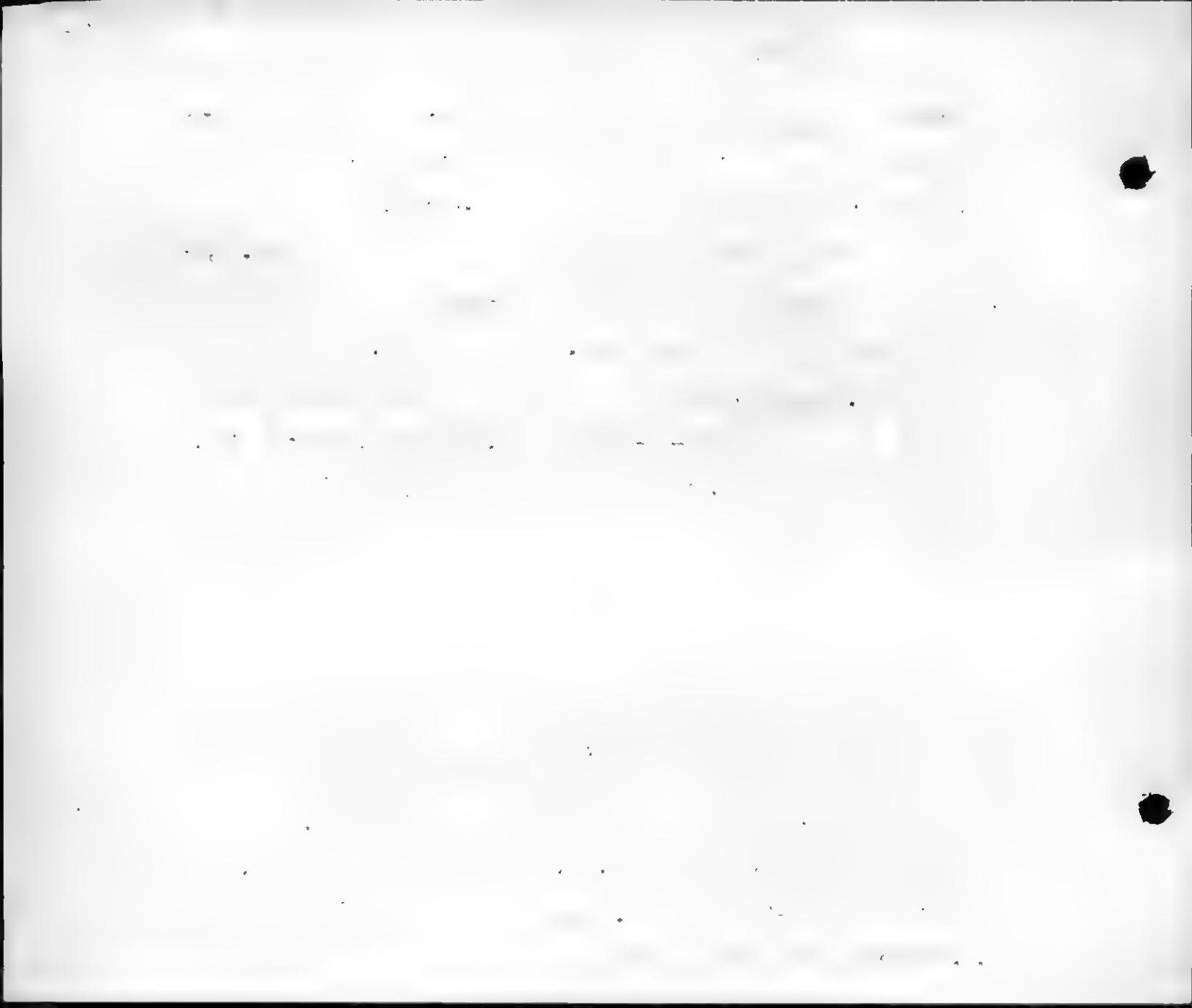
12652

CERTIFICATE OF DEATH

12652

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		b. COUNTY Howard	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Nursing Home		d. STREET ADDRESS St. Johns Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ETHEL	Middle VIRGINIA	Last IGLEHART
4. DATE OF DEATH	Month Nov.	Day 21, 1959	Year 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-1899
9. AGE (in years last birthday) 60	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper	10b. KIND OF BUSINESS OR INDUSTRY Miller Chev.	11. BIRTHPLACE (State or foreign country) Howard Co. Md	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Geo. Edward Wheatley		14. MOTHER'S MAIDEN NAME Mary Virginia Ames	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-22-1966	17. INFORMANT John. W. Iglehart, Ellicott City, Md	18. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Cervix cancer of the rectum		INTERVAL BETWEEN ONSET AND DEATH 1 yrs.	
4X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION STATED IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/1/59 to 11/21 , 1959, that I last saw the deceased alive on 11/20 , 1959, and that death occurred at 8:57 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 46 Church Rd.			
ACTUAL SIGNATURE <i>Thomas F. Herbert, M.D.</i>		DATE SIGNED 11-21-59	
PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 11-24-59		22c. NAME OF CEMETERY OR CREMATORIAL Mt. View	
22d. LOCATION (City, town, or county) Alpha, Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
		24b. REGISTRAR'S SIGNATURE Arthur J. Times	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12653

CERTIFICATE OF DEATH

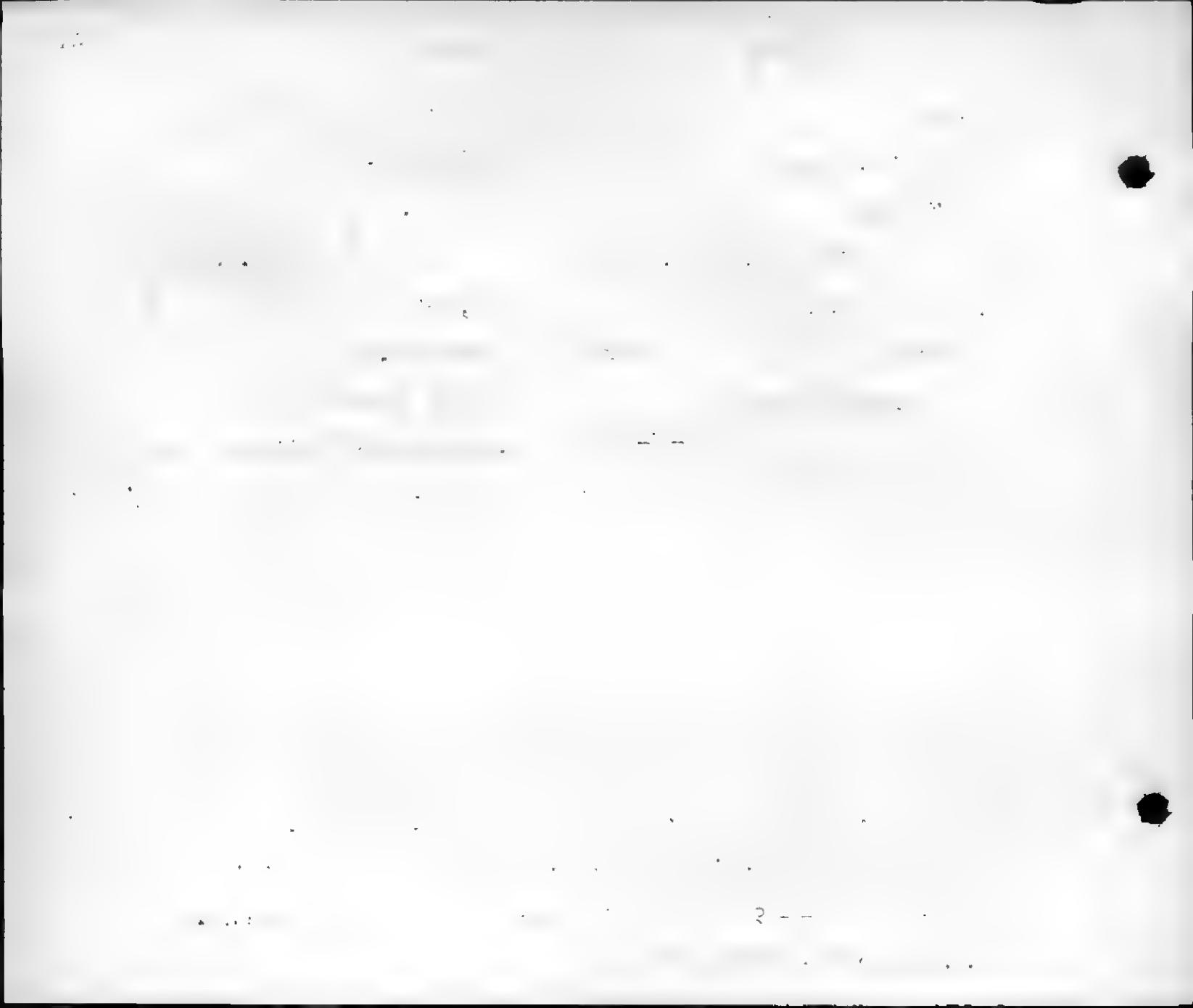
Reg. Dist. No.

12653

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		d. STREET ADDRESS Hill St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hill St.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JOHN LEMLY IGLEHART		First	Middle	Last	4. DATE OF DEATH Nov. 5, 1959	Month	Day	Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1886	9. AGE (In years lost birthday) 73	10. IF UNDER 1 YEAR Months 73	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Howard Co., Md		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William Iglehart		14. MOTHER'S MAIDEN NAME Mary Harding						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 219-30-7549		INFORMANT Mrs. Mary Iglehart, Ellicott City, Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1		DUE TO Cowpox		INTERVAL BETWEEN ONSET AND DEATH 10 min				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, - Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 1-20 , 19 58 , to 8-14 , 19 58 , that I last saw the deceased alive on 8-14 , 19 58 , and that death occurred at 9:10 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 46 Church St. DATE SIGNED 11-6-59								
ACTUAL SIGNATURE Thomas F. Herbert		M.D.						
PHYSICIAN'S NAME (Type) Thomas F. Herbert, M. D.		Ellicott City, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-59		22c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



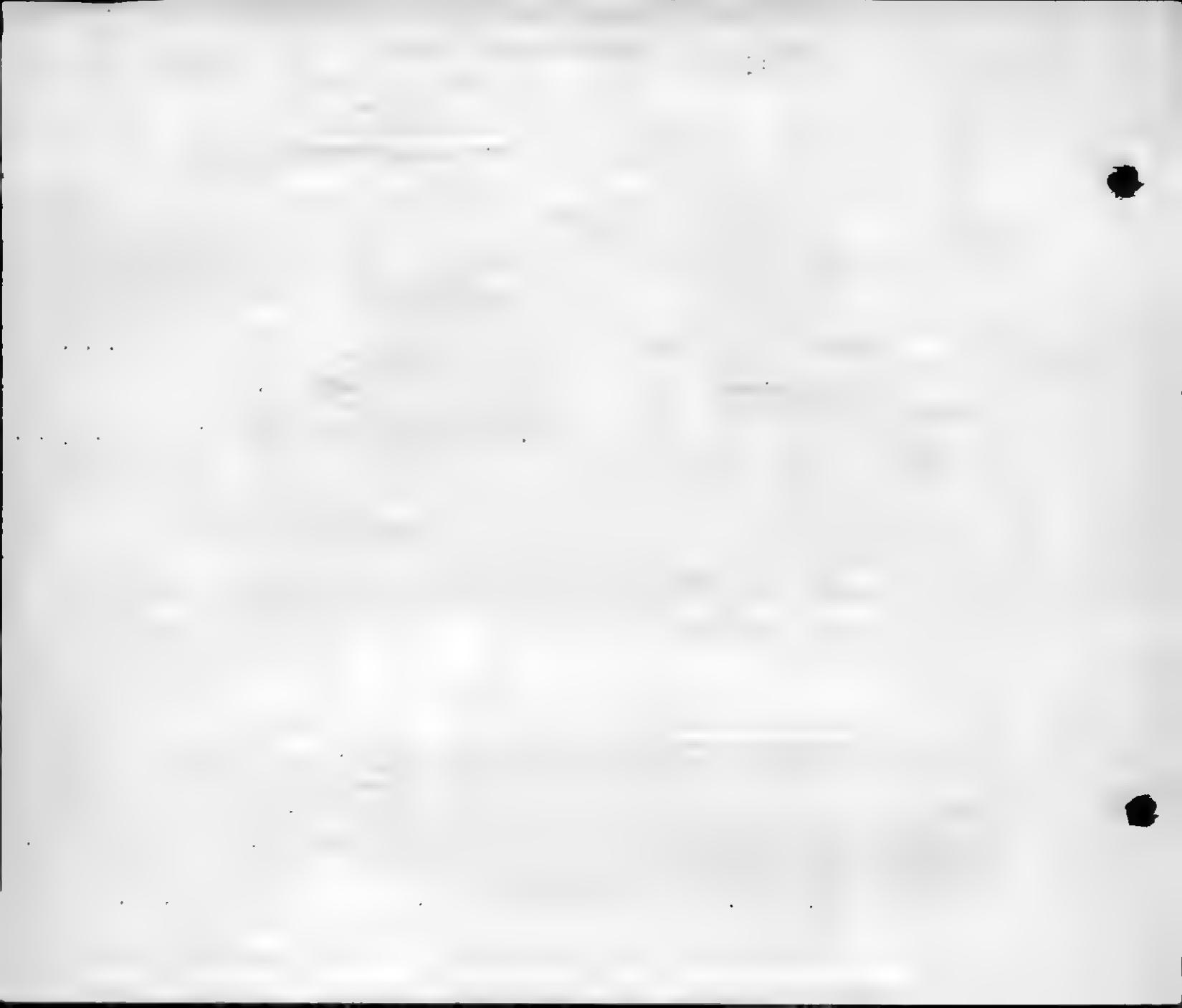
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12654

CERTIFICATE OF DEATH

Reg. Dist. No. 12640

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN lb 3 yrs 7 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2004 Linden Avenue Baltimore		d. STREET ADDRESS 2004 Linden Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Jacob		First	Middle	Last	4. DATE OF DEATH November 23	Month November	Day 23	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1889	9. AGE (in years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Louis Kleinman		14. MOTHER'S MAIDEN NAME Bertha ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Max Kleinman- 7222 Park Heights Ave. Apt.A.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac failure				INTERVAL BETWEEN ONSET AND DEATH 8 MOS.		
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.		(b) Arteriosclerotic Cardiovascular disease				years		
		(c) General arteriosclerosis				years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Erythema multiforme 11 days						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from April 20, 1956, to Nov 23, 1959, that I last saw the deceased alive on Nov. 23, 1959, and that death occurred at 10:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state)								DATE SIGNED 11/23/59
ACTUAL SIGNATURE Irving J. Taylor, M.D.				M.D. Taylor Manor Hosp.				
PHYSICIAN'S NAME (Type)				Taylor Manor Hospital, Ellicott City, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 24/59.		22c. NAME OF CEMETERY OR CREMATORIUM Arlington, Rogers Ave.		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE M. L. Kleinman		ADDRESS 1124-26 21. mtell Ave		24a. REC'D BY REGISTRAR DATE NOV 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 File #252 11-30-59 et

12641

12655

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Howard

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Ellicot City

c. LENGTH OF STAY IN 1b

202110.

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Old Frederick Rd. Rd2

3. NAME OF
DECEASED
(Type or print)First: Naylor
Middle: William H.2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE

Md.

b. COUNTY

Howard

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Ellicott

d. STREET ADDRESS

Old Frederick Road

e. IS RESIDENCE
ON A FARMS
YES NO

5. SEX

Male

White

6. COLOR OR RACE
7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH

1-28-1889

9. AGE (In years
lost birthday) 70

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Plaster

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Naylor

14. MOTHER'S MAIDEN NAME

Amanda Curtis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

213-01-7812

17. INFORMANT

Minnie Naylor

Old Frederick Road
Ellicott, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

myocardial failure

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause first.

(b)

DUE TO

(c)

myocardial failure
ArteriosclerosisINTERVAL BETWEEN
ONSET AND DEATHfew hours
years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)
(County) (State)21. I certify that I attended the deceased from 11/1/19, 1959, to 11/22, 1959, that I last saw the deceased
alive on 11/19, 1959, and that death occurred at 8:30 M, from the causes and on the date stated above.ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)22b. DATE THEREON
11-25-195922c. NAME OF CEMETERY OR CREMATORIAL
Methodist22d. LOCATION (City, town, or county)
Butler, Md. (State)23. FUNERAL DIRECTOR'S SIGNATURE
Grant A. SeitzADDRESS
814 W 36th Baltimore 11 Md.24a. REC'D BY REGISTRAR
DATE NOV 25 '5924b. REGISTRAR'S SIGNATURE
Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12656

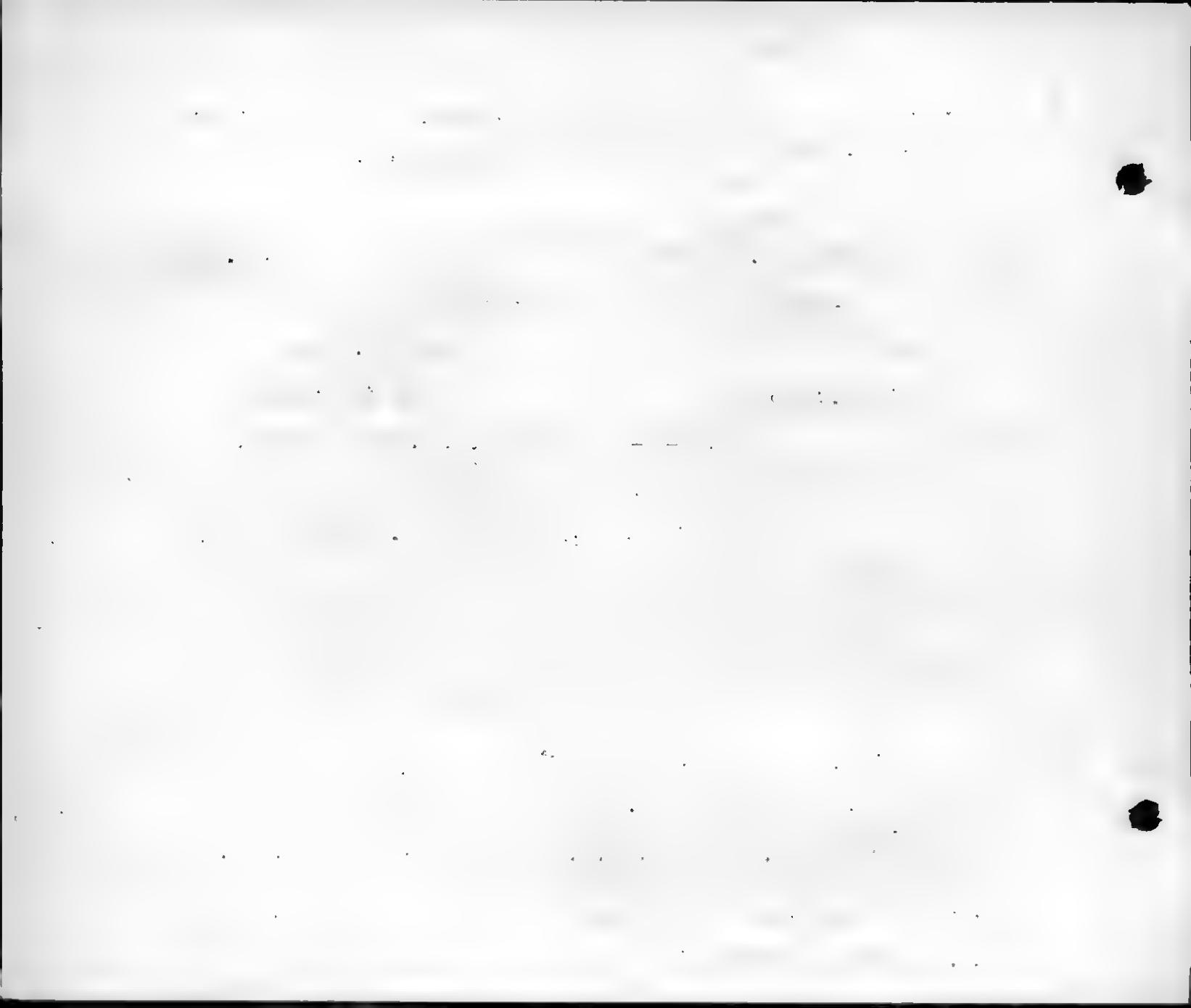
CERTIFICATE OF DEATH

Reg. Dist. No. 12642

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CHARLES H. NELSON		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1-20-1885	9. AGE (in years last birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Howard Co. Md		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William H. Nelson		14. MOTHER'S MAIDEN NAME Hattie Rhodes						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-07-8921		INFORMANT Donald Clark, Marriottsville, Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]						INTERVAL BETWEEN ONSET AND DEATH 6 hrs.		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		DUE TO <i>Cardiac failure</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arterosclerotic cardiovascular disease		(b) DUE TO <i>Arterosclerotic cardiovascular disease</i>		(c)		(10 yrs.)		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 11-26 , 19 57 , to 11-26 , 19 57 that I last saw the deceased alive on 11-26 , 19 57 , and that death occurred at 7:50 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Thomas F. Herbert</i>		ADDRESS (Street, city or town, state) 46 Church Road DATE SIGNED 11-27-57						
PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.		Ellicott City, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-30-59		22c. NAME OF CEMETERY OR CREMATORIUM West Liberty		22d. LOCATION (City, town, or county) Alpha, Md		
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 30 '59		24b. REGISTRAR'S SIGNATURE <i>James S. Turner</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail necessary, please execute the certificate, writing the word "Pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12643

12653

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
a. COUNTY		a. STATE	
Howard		Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Jessups		Howard	
c. LENGTH OF STAY IN 16		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Jessups	
Guilford Road, Box 75		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		e. IS RESIDENCE ON A FARM?	
First Middle		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MELVIN S. NOBLES		e. IS RESIDENCE ON A FARM?	
5. SEX		6. COLOR OR RACE	
Male Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		August 18, 1959	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
None		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Samuel Shing		Mable Nobles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, date of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
No		None Mable Nobles	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Jessups, Maryland	
412		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
19. WAS AUTOPSY PERFORMED?			
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> end in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Burial 11/7/59		Address (Street, city, town, or county)	
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or country) (State)	
11/7/59		Mt. Auburn Baltimore Md.	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
Arlington S. Phillips 1808 N. Monroe		NOV 10 '59 Arthur S. Thomas	

1st. of Twins

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any details necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12644

1. PLACE OF DEATH

a. COUNTY

Howard 12658

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Poplar Spring

c. LENGTH OF STAY IN HS

1 Day

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

1 1/2 mi. North of Rt. 40 on Beetz Road

3. NAME OF
DECEASED
(Type or print)

Ben

Middle

VICTOR

5. SEX

Male

6. COLOR OR RACE

White

WIDOWED

DIVORCED

Never Married

7. MARRIED

Feb. 14, 1904

8. DATE OF BIRTH

1907

11. BIRTHPLACE (State or foreign country)

Feb. 14, 1904

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Witold Skarzinski

14. MOTHER'S MAIDEN NAME

Antoinette Zanawach

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give war record or dates of service)

No None

16. SOCIAL SECURITY NO.

193-03-7600

Mrs. Mary Skarzinski

17. INFORMANT

1765 Melbourne Rd.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic Cardiovascular Disease.

INTERVAL BETWEEN
ONSET AND DEATH

DUE TO

(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or Town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL
SIGNATURE

Charles S. Petty

M.D.

ASSISTANT MEDICAL EXAMINER

EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

DEPUTY MEDICAL EXAMINER

DATE SIGNED

11/4/59

22a. BURIAL OR CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

(State)

Burial

Nov. 7, 1959

Sacred Heart of Jesus German Hill Rd. Md.

23. FUNERAL DIRECTOR

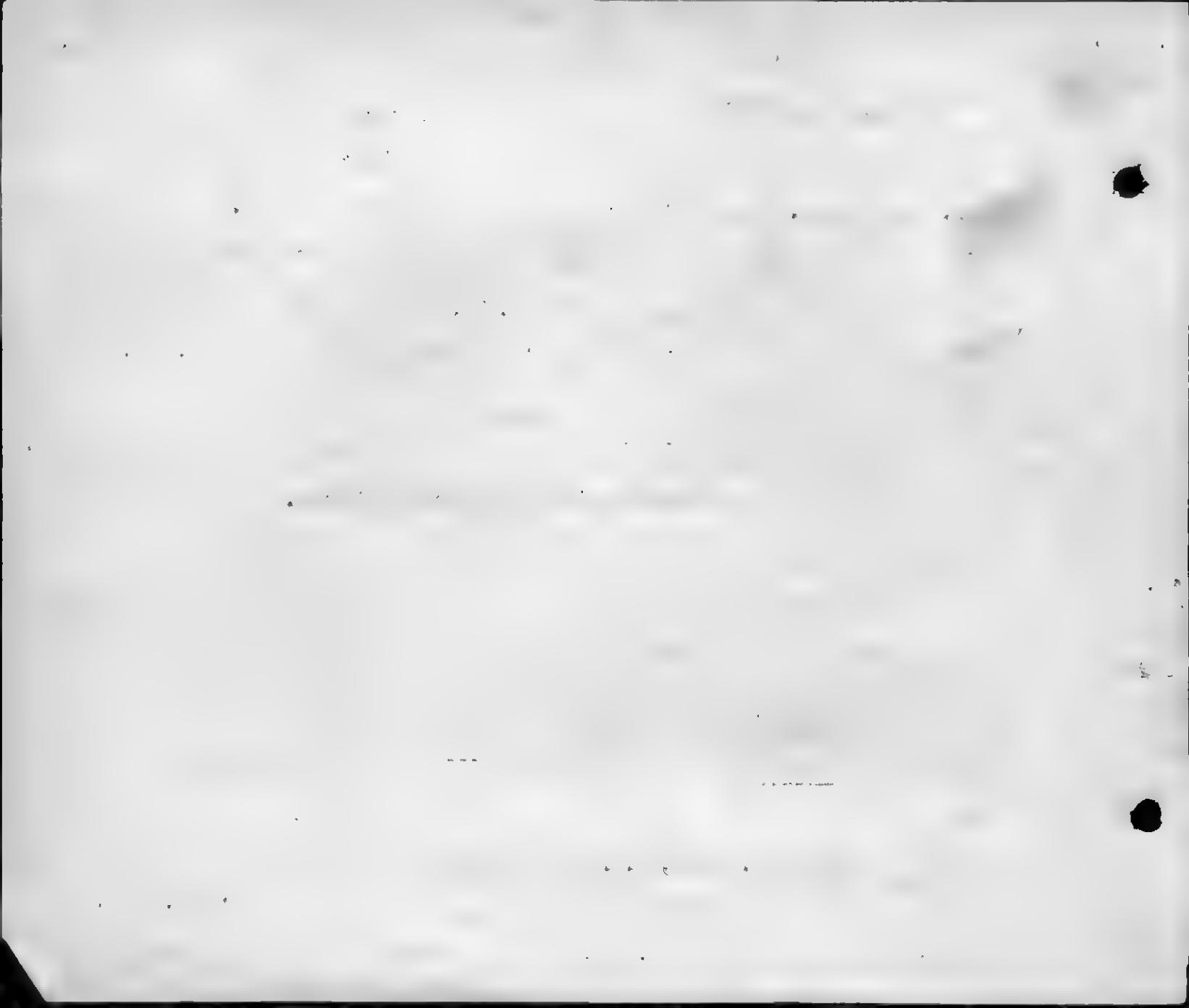
ADDRESS

24a. REC'D BY REGISTRAR

NOV 6 '59

24b. REG STAR'S SIGNATURE

Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12659 CERTIFICATE OF DEATH 12645
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltw.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine -rural-		c. LENGTH OF STAY IN 1b 4 wks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 0352-2	
3. NAME OF DECEASED (Type or print) Julia May Walker		First	Middle
		Last	4. DATE OF DEATH Nov. 25 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-1881
9. AGE (In years last birthday) 78 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.	13. FATHER'S NAME Robert Beall		
14. MOTHER'S MAIDEN NAME Mary Jane Hobbs	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. none	17. INFORMANT Mr. Jesse C. Walker, Woodbine, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive Heart Failure Acute & chronic Degenerative Heart Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at
20f. (City or town) Catonville	(County) Md.	(State) Md.	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 500A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE K. E. McGrath	ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonville 28 Md. DATE SIGNED 11/26/59		
PHYSICIAN'S NAME (Type) K. E. McGrath			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-28-1959	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet	22d. LOCATION (City, town, or county) Frederick, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,	ADDRESS Winfield, Md.	24a. REG'D BY REGISTRAR NOV 30 '59 DATE	24b. REGISTRAR'S SIGNATURE Arthur S. Thorne

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **12646**

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Simpsonville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffer Convalescent Retreat		e. STREET ADDRESS none	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PAULINE		First PAULINE	Middle
4. DATE OF DEATH Nov. 17 1959		Last WHITE	Month Nov. Day 17 Year 1959
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? 		13. FATHER'S NAME Henry Friedrich	
14. MOTHER'S MAIDEN NAME Bernhardt Miller		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 	
16. SOCIAL SECURITY NO. 		INFORMANT Thelma Mulley - Ellicott City, Maryland	
17. ADDRESS 		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) CARDIAC ARREST	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c). 422.1		DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) AND PNEUMONIA -	
19. INTERVAL BETWEEN ONSET AND DEATH 10 yrs		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Fractured RT. Hip	
20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fall at home -	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10-6 19 59		20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) SIMPSONVILLE, HOWARD, MD.	
21. I certify that I attended the deceased from 1957 , 19, to 11-16 , 19 59 that I last saw the deceased alive on 11-16 , 19 59 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Peter V. Thorpe		22. ADDRESS (Street, city or town, state) COLUMBIA RD	
23. PHYSICIAN'S NAME (Type) PETER V. THORPE MD		24. DATE SIGNED 11-17-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/20/59	
22c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company-Washington, DC		24a. REC'D BY REGISTRAR DATE NOV 19 '59	
ADDRESS 		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

